Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CY-FAIR CHIROPRACTIC ASSOC

Respondent Name
METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number
M4-17-1046-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
DECEMBER 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position summary was not submitted.

Amount in Dispute: $807.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that a large number of the charges listed on the DWC060 have been paid at fee schedule…Starr Comprehensive Solutions maintains that these servces exceed the Commissioner's adopted treatment guidelines or protocols and required preauthorization. There has been no preauthorization requested for these DOS."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 2016	CPT Code 99213-25 Office Visit	$55.00	$0.00
June 6, 2016	CPT Code 98940 Chiropractic Manipulation, Spinal 1-2 regions	$55.00	$0.00
June 6, 2016	CPT Code 98943 Chiropractic Maipulation, Extraspinal 1 or more regions	$58.00	$0.00
June 14, 2016	CPT Code 99212-25 Office Visit	$75.00	$0.00
June 14, 2016	CPT Code 98940 Chiropractic Manipulation, Spinal 1-2 regions	$55.00	$0.00
June 14, 2016	CPT Code 98943 Chiropractic Maipulation, Extraspinal 1 or more regions	$58.00	$0.00
July 11, 2016	CPT Code 99212 Office Visit	$75.00	$0.00
August 10, 2016	CPT Code 99212-25 Office Visit	$75.00	$0.00

August 10, 2016	CPT code 98940 Chiropractic Manipulation, Spinal 1-2 regions	$55.00	$46.01
August 10, 2016	CPT Code 98943 Chiropractic Maipulation, Extraspinal 1 or more regions	$58.00	$0.00
September 21, 2016	CPT Code 99212-25 Office Visit	$75.00	$0.00
September 21, 2016	CPT Code 98940 Chiropractic Manipulation, Spinal 1-2 regions	$55.00	$46.01
September 21, 2016	CPT Code 98943 Chiropractic Maipulation, Extraspinal 1 or more regions	$58.00	$0.00
TOTAL		807.00	$92.02

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective July 1, 2012,requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
5. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 197-Payment denied reduced for absence of precertification/authorization.
   - W3-Additional reimbursement made on reconsideration.

Issues

1. Does a preauthorization issue exist?
2. Is the requestor entitled to additional reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the chiropractic manipulations rendered on August 10 and September 21, 2016 based upon a lack of preauthorization.

   Per 28 Texas Administrative Code §134.600(p)(12 the non-emergency healthcare that requires preauthorization includes: "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   According to the Neck and Upper Back Chapter of the Official Disability Guidelines (ODG), manipulations are a recommended treatment for cervical spine injuries; therefore, the disputed manipulations, CPT codes 98940 and 98943 do not require preauthorization.

2. The Division refers to 28 Texas Administrative Code §134.203(c)(1)(2), which states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2016 DWC conversion factor for this service is 56.82.

The Medicare Conversion Factor is 35.8043.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77065, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston, Texas".

Using the above formula, the Division finds the following:

Dates of Service	CPT Codes	Medicare Participating Amount	MAR	Amount Paid	Check No.	Amount Due
June 6, 2016	99213-25	$74.16	$117.69	$117.69	322712	$0.00
June 6, 2016 June 14, 2016 August 10, 2016 September 21, 2016	98940	$28.99	$46.01	$46.01 $46.01 $0.00 $0.00	322712 322617	$92.02
June 6, 2016 June 14, 2016 August 10, 2016 September 21, 2016	98943	Not priced by Medicare	F&R	$44.26 $44.26 $0.00 $0.00	322712 322617	$0.00
June 14, 2016 July 11, 2016 August 10, 2016 September 21, 2016	99212-25	$44.09	69.97	$69.97 $69.97 $69.97 $69.97	322617 322712 323089 323898	$0.00

Because CPT code 98943 is not priced by Medicare the division refers to 28 Texas Administrative Code §134.203(f) which states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

The requestor is seeking $58.00 for each CPT code 98943. 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment

amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." A review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of $58.00 for CPT code 98943 would be a fair and reasonable rate of reimbursement. As a result reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $92.02.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $92.02 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		1/26/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.